

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1070

FILED FEB 11 1942

State File No.

179

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 309 Garfield Hospital No. 1 - Outpatient
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution --
(Specify whether
In this community Since December 29, 1941.
years, months or days)

3. (a) PRINT FULL NAME Joseph C. Baker

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife Katie C. Baker 6. (c) Age of husband or wife if alive X years
7. Birth date of deceased November 25 1866
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 29 If less than one day
hr. min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Contractor

11. Industry or business X

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant W. E. Reilly
(b) Address Topeka, Kansas
17. (a) Removal (b) Date thereof 1-14-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Topeka, Kansas

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 1-15-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 309 Garfield
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14th
year 1942 hour 11:10 minute A. M.

21. I hereby certify that I attended the deceased from about Jan. 7th 1942 to Jan. 14th 1942, 19...;
that I last saw him alive on January 14th, 1942, 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral hemorrhage

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Amey R. Thorn (M. D. or other)
Address Med. Dir. K. C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~was embalmed~~ by me, or by

working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.